2013 STATE HEALTH BENEFIT PLAN (SHBP)

Biometric Screening - Physician Screening Form

(physician biometric screenings completed from July 1, 2012 through May 31, 2013)

Results from biometric screening (blood pressure, BMI, cholesterol, glucose) provided by physician must be faxed from the physician's office to 1-866-380-5068, using the attached Physician Screening Form.

The physician must complete all of the biometric screening results identified on the attached form, record the screening results (see section 2) on the form, and per the instructions provided below, sign and submit the completed fax form to 1-866-380-5068 by 4:30 pm EST on May 31, 2013.

Timely submission of the properly completed form will **ONLY** satisfy the biometrics screening requirements for 2013.

[These results must be submitted by the physician, as self-reporting by the Member or Spouse will not meet the requirements for 2013.]

All results submitted to the SHBP are protected by law, as described in the SHBP Notice of Privacy Practices.

INSTRUCTIONS FOR SHBP PARTICIPANT

Complete SECTION 1 of the FAX form including **name as shown on your insurance card** AND present the form to your physician at your scheduled appointment. Instruct the physician to complete biometric screening, record the required data in SECTION 2 and SECTION 3 and fax the form directly to SHBP Administrator at 1-866-380-5068.

If you completed a biometric screening since July 1, 2012 you may take the form to your physician and request completion of SECTIONS 2 and 3 with your results and submission of the form.

Remember, your annual preventive care is covered at 100% if provided by an in-network physician. This means you are not responsible for a copay or coinsurance. Talk to your physician about using one of the codes below to make sure your visit is processed correctly.

COMPLETED FORMS MUST BE RECEIVED BY THE SHBP ADMINISTRATOR ON OR BEFORE 4:30 PM EST MAY 31, 2013 TO QUALIFY

INSTRUCTIONS FOR PHYSICIAN

Complete SECTION 2 and SECTION 3 of the Physician Fax Form, sign where indicated, and fax to the SHBP Administrator at 1-866-380-5068

Fasting results are not required but may be submitted if available. Please use one of the codes below.

99385 - New, Ages 18-39
99386 - New, Ages 40-64
99387 - New, Ages 65 & over

99395 - Established, Ages 18-39
99396 - Established, Ages 40-64
99397 - Established, Ages 65 & over

2013 State Health Benefit Plan (SHBP)
Biometric Screening - PHYSICIAN SCREEENING FORM
Fax to - 1-866-380-5068

Dear Physician,
I am a Georgia SHBP Plan member. As a member of the plan I have agreed to complete a biometric screening with the results to be submitted to SHBP as detailed on the previous page. Please complete SECTION 2 and SECTION 3 below, sign in SECTION 3, and fax the completed form to 1-866-380-5068 *no later than 4:30 pm EST on May 31, 2013.*
Thank you.

SECTION 1: PATIENT INFORMATION (*PATIENT - Please print as shown on your insurance card*)

First Name **Middle Initial** **Last Name**

Street Address **City** **State** **Zip**

Phone Number : ( ) - **2013 Member ID#** | ***or*** | **CIGNA** | **United Healthcare**

Check Gender: **Male** **Female** **Age:** **Date of Birth:** **Month** **Date** **Year**

Patient Disclosure Statement: I understand that my biometric screening data will be submitted to SHBP's incentive administrator and SHBP for incentive purposes, and will remain confidential and will be protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA). I am voluntarily participating in this biometric screening.

PATIENT SIGNATURE **DATE**

*PATIENT: Biometric Screenings must be completed between July 1, 2012 and May 31, 2013 and submitted by **4:30 pm EST on May 31, 2013.** If you have questions or need additional assistance, please call the number on the back of your Insurance ID card.*

SECTION 2: PATIENT BIOMETRIC SCREENING VALUES *(PHYSICIAN to complete this section. Please print)*

*****Required Screening Information*****

Exam Date: ____ / ____ / ____
Month Day Year

Height: _____ *Feet* _____ *Inches*
Weight: _____ *lbs* _____ BMI

Total Cholesterol: _____ mg/dl
HDL Cholesterol: _____ mg/dl
LDL Cholesterol: _____ mg/dl

Glucose: Fasting _____ mg/dl
OR
Non-Fasting _____ mg/dl

Blood Pressure: _____ mmHg

SECTION 3: PHYSICIAN INFORMATION

Provider's name: _____ **Phone Number:** ( ) -
(Please Print) **First** **Last**

Fax Number : ( ) -

Street Address **City** **State** **Zip**

PHYSICIAN'S SIGNATURE (required) **DATE**